Ontario Health atHome

250 Dundas Street West, Suite 305, Toronto, ON M5T 2Z5
Tel: 416-506-9888 | 1-866-243-0061
Fax: 416-506-0374
www.ontariohealthathome.ca

REFERRAL FORM FOR ONTARIO HEALTH ATHOME

PLEASE FAX COMPLETED REFERRAL FORM TO ONTARIO HEALTH ATHOME 416-506-0374
PLEASE PRINT CLEARLY

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME: _____

HEALTH CARD #_____ VC_____ DATE OF BIRTH: DD_____ MM_____ YYYY_____

ADDRESS:_____ APT#_____ ENTRY CODE: _____

CITY:_____ PROVINCE:_____ POSTAL CODE:_____

PRIMARY TELEPHONE #: _____ ALTERNATE: _____

PREFERRED LANGUAGE: _____

PRIMARY CONTACT INFORMATION

LAST NAME:_____ FIRST NAME: _____

PRIMARY TELEPHONE #: _____ ALTERNATE: _____

PREFERRED LANGUAGE: _____

Reason for Ontario Health atHome Referral:

Has the Patient fallen within the last 30 days?: Yes ☐ No ☐
Was the Patient in hospital within the last 30 days?: Yes ☐ No ☐
Is the Patient POA/SDM aware of this referral?: Yes ☐ No ☐

REFERRAL SOURCE

NAME:_____ TELEPHONE: _____ FAX: _____

ADDRESS:_____ CITY:_____ PROVINCE:_____ POSTAL CODE:_____

PHYSICIAN / NURSE PRACTITIONER INFORMATION

REFERRING: ☐ PRIMARY CARE PRACTITIONER: ☐

NAME:_____ TELEPHONE: _____ FAX: _____

ADDRESS:_____ CITY:_____ PROVINCE:_____ POSTAL CODE:_____

OHIP BILLING CODE:_____ CPSO# _____

SIGNATURE: DATE:

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE OF. CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.

RREFERRAL FORM FOR ONTARIO HEALTH ATHOME

PLEASE PRINT CLEARLY

LAST NAME:_____ **FIRST NAME:** _____
HEALTH CARD #_____ **VC**_____

MEDICAL INFORMATION		
PRIMARY DIAGNOSIS		
SECONDARY DIAGNOSIS		
ALLERGIES		
RELEVANT MEDICAL HISTORY		
MEDICATION	**Name:**_____ **Dosage:**_____ **Frequency:**_____ **Route:**_____ **Duration:**_____ **Name:**_____ **Dosage:**_____ **Frequency:**_____ **Route:**_____ **Duration:**_____ **Name:**_____ **Dosage:**_____ **Frequency:**_____ **Route:**_____ **Duration:** _____ **Other:** _____	
MOBILITY	**Ambulatory:** ☐ **Yes** ☐ **No** **Patient uses:** ☐ **Wheelchair** ☐ **Walker** ☐ **Cane** ☐ **Scooter** **Other:**_____	
SERVICES REQUESTED	***Mandatory Information*** 1. Identify reason/need for each services selected 2. Provide Treatment Orders and Start Date as applicable 3. For Nursing Service - Patients will receive assessment and treatment at one of the Ontario Health atHome Nursing Clinics (in-home nursing arranged by exception only) 4. Fax referral AND relevant documents together (i.e. script, Palliative Care Referral Form, etc	
☐ **Nursing** (including Nursing Clinics) ☐ **Personal Care** (bathing/dressing) ☐ **Dietician/Nutrition** ☐ **Occupational Therapy** ☐ **Physiotherapy** ☐ **Speech Language Pathology** ☐ **Social Work** ☐ **LTCH Assessment** ☐ **Case Management** ☐ **Community Linking** (i.e. home making)		
☐ **Palliative**	**Prognosis:** _____ **Palliative Performance Scale (PPS):**_____ **%**	
☐ **Rapid Response Nursing (RRN)**	☐ **CHF** ☐ **COPD**	
Physician/NP Name:		**OHIP Billing Code:** _____ **CPSO/CNO#:**_____
Physician/NP Signature:		**Date:**_____

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